PSYCHOLOGY SPECIALISTS OF MAINE

Therapy for Individuals and Couples

Intake Form

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

NAME(S) _____ Address_____

Date of Birth_____ Age _____ City, State _____ Zip _____

Ethnicity _____ Email _____

Relationship Status_____ Preferred Phone _____

May we leave a voice message on your phone?_____

Relationship to Responsible Party (check one): Self_____ Child_____ Other _____

Relative or friend in case of emergency _____

Name Phone # Relationship

How did you hear about us? _____

Have had any previous therapy? If so, when and with whom?_____

_____

FINANCIAL

Insurance name _____

Insurance ID number _____

Policy Holder Name _____

Please note that our psychologists accept in-network benefits for Anthem Blue Cross/ Blue Shield only. All other insurances are accepted as out-of-network.

I understand that if I cancel within 24 hours or do not show up for an appointment. I will be billed $100 for the missed session. I have been given the opportunity to ask questions regarding this statement.

_____ _____ _____

Signature of Responsible Party Printed Name Date

MEDICAL INFORMATION

1. **Patient Name** _____

Physician: Name/Practice _____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

How is your general health now? _____

List Medications_____

Are you presently being treated by a physician for any physical condition? _____

Have you had any serious illness? (List) _____

Have you ever had any surgery? (List) _____

List all Medications:

2. **Patient Name (partner/family member if applicable)**_____

Have you ever had therapy in the past? (When and Where?) _____

_____

Physician: Name/Practice _____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

How is your general health now? _____

List Medications_____

Are you presently being treated by a physician for any physical condition? _____

Have you had any serious illness? (List) _____

Have you ever had any surgery? (List) _____

PLEASE MARK ALL THAT APPLY: (If more than one patient, please separately initial)

___Academic	___Grief / Loss	___Physical Aggression
___Adjustment	___Guilt	___Relationship Problems
___Anxiety	___Hallucinations	___Self Abusive Behavior
___Changes in Appetite/Eating Habits	___Hopelessness	___ Sexual Identity
___Career	___Impulsiveness	___Sleep Disturbance
___Decreased Energy	___Interpersonal Conflicts	___Somatic Complaints
___Delusions	___Irritability	___Suicidal Thoughts
___Depressed Mood	___Manic	___Substance Abuse
___Disruption of Thought Process/Content	___Mood Swings	___Weight Loss
___Emotional/Physical/Sexual Trauma	___Panic Attacks	___Worthlessness
___Excessive Crying		___Other (Specify)
___Family Issues		

Reasons for seeking therapy?